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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2954 **CERTIFICATE OF DEATH**

02932

Reg. Dist. No. 191

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Howard		STATE Md.		COUNTY Howard			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Ellicott City				TOWN Ellicott City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Linwood Drive & Walnut Rd.				STREET ADDRESS (If rural give location) Linwood Drive and Walnut Rd.			
3. NAME OF DECEASED (First) (Middle) (Last) JOHN CARROLL BEHR				4. DATE OF DEATH (Month) (Day) (Year) Mar. 29, 1956			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Dec. 3, 1895		9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Supt.		10b. KIND OF BUSINESS OR INDUSTRY Riggs Distler Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Valentine Behr				14. MOTHER'S MAIDEN NAME Anna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Ellicott City, Md. Mrs. Lillian M. Behr-Linwood & Walnut			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) Metastatic Carcinoma of Brain						INTERVAL BETWEEN ONSET AND DEATH 3 weeks.	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of Rectum						8 mos	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Diabetes Mellitus							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1/23/56		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Rectum				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 9, 1956, to March 29, 1956, that I last saw the deceased alive on 3/28, 1956, and that death occurred at 3:00 A.M. from the causes and on the date stated above.							
SIGNATURE Robert Phochal M.D.				ADDRESS (Street, city, town, state) 4111 Liberty Street 3/30/56 STATE			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/2/56		NAME OF CEMETERY OR CREMATORY Lorraine Park		LOCATION (City, town, or county) Woodlawn, Md.	
24. REC'D BY REGISTRAR APR 5 1956		REGISTRAR'S SIGNATURE John Dougherty		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltimore			

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CLERK

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF JURY

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

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BUREAU V. S.

APR 3 1956

RECEIVED

2955 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Howard		MARYLAND		STATE Maryland COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 31014			
X TOWN Ellicott City				STREET ADDRESS (If rural give location) 936 Abbott Court			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home							
3. NAME OF DECEASED: (Type or Print)		(First) ROSE		(Middle) IRENE		(Last) BELL	
5. SEX: female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		4. DATE (Month) (Day) (Year) OF DEATH: March 21, 1956	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home		8. DATE OF BIRTH: 1888		9. AGE last birthday 67 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: William Harwood				14. MOTHER'S MAIDEN NAME: Margaret Keith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) --				16. SOCIAL SECURITY NO. 217-205893B		17. INFORMANT & ADDRESS: Albert Crouse, 1622 East 32nd Street	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.0 Anterior inferior Heart Myocard						? year	
ANTECEDENT CAUSE (B) Chronic Bronchitis + Emphysema						? year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Pulmonary Edema							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June, 1955 , to Mar 21, 1956 , that I last saw the deceased alive on Mar 18, 1956 , and that death occurred at 11A M. from the causes and on the date stated above.							
SIGNATURE Wm. J. Hilly				DATE SIGNED 3/22/56			
M. D. 5226 Balt. Nat. Pike							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		DATE THEREOF 3/23/56		NAME OF CEMETERY OR CREMATORY Green Mount Crematory		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-22-56		REGISTRAR'S SIGNATURE A. W. Hedrick		24. FUNERAL DIRECTOR Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2956 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02934

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Natwick Road				d. STREET ADDRESS Natwick Road			
3. NAME OF DECEASED (Type or print) First SHARON Middle JEAN Last CAVEY				4. DATE OF DEATH Month March Day 10 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1955		9. AGE (In years last birthday) yrs. 3 Months 18 Days 18	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Lee Cavey				14. MOTHER'S MAIDEN NAME Laura Crone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lee Cavey Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 48 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George E. Burgtorf</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. George E. Burgtorf				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Howard County 3-11-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-56		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR March 12, 56		24b. REGISTRAR'S SIGNATURE <i>John B. Loughran, Jr.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

RECEIVED

2957

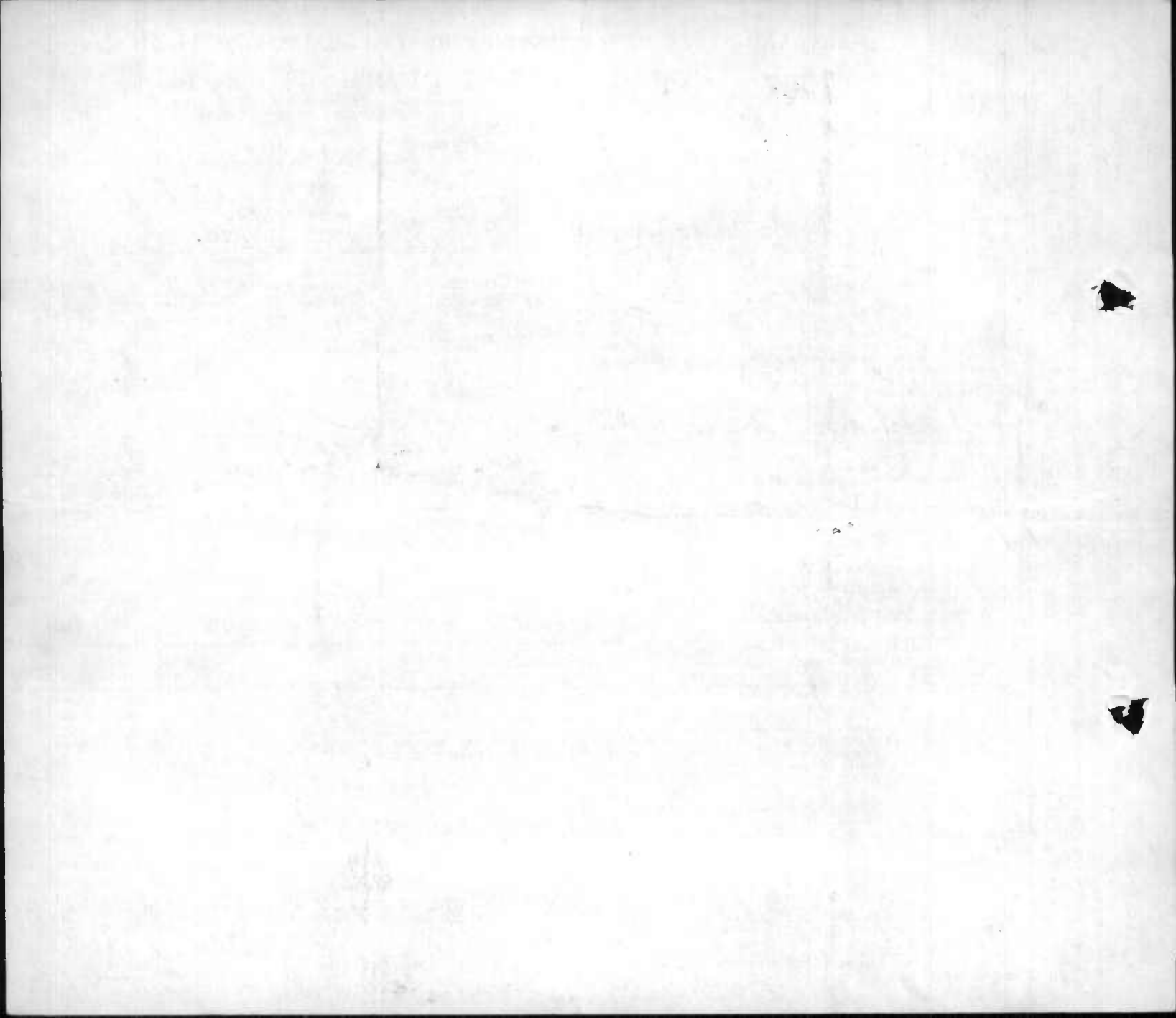
CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ellicott City</u>		<u>13</u> days		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>				STREET ADDRESS (If rural give location) <u>3310 Avondale Ave.</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Ethel</u>		(Middle)		(Last) <u>Cohen</u>		OF DEATH: <u>March 7</u> 19 <u>56</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Dec 22, 1914</u>	
9. AGE last birthday <u>41</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Leeds, England</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Abraham Lewis</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Marcus Cohen - Same</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>48 hrs</u>	
ANTECEDENT CAUSE (B) <u>Psychotic Depressive Reaction</u>						<u>10 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Epilepsy</u>						<u>10 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 23, 1956</u> to <u>March 7, 1956</u> , that I last saw the deceased alive on <u>Mar. 7</u> , 1956, and that death occurred at <u>7:50 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur V. Mitchell, Jr.</u>				ADDRESS <u>Taylor Manor Hospital</u> DATE SIGNED <u>March 7, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>7-8-56</u>			
NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>				LOCATION (City, town, or county) (State) <u>Balto Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>3-8-56</u>				REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>			
24. FUNERAL DIRECTOR <u>Jack Lewis</u>				ADDRESS <u>2100 Eutaw Pl</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02936

2953

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 2, Film G194 4-3-56 et

1. PLACE OF DEATH COUNTY <u>Howard</u> CITY <u>ELLICOTT CITY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Howard</u> City <u>Ba</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ELLICOTT CITY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ELLICOTT CITY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HIGHLAND MANOR NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>1802 Linden Avenue Balto.</u>	
3. NAME OF DECEASED (Type or Print) <u>MOSES</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>21</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>RETIRED</u>	8. DATE OF BIRTH <u>JULY 5, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SOLOMON DE BEER</u>		14. MOTHER'S MAIDEN NAME <u>FREDERICA HEYMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-03-168A</u>	
17. INFORMANT AND ADDRESS <u>SIDNEY EICHENGREEN</u> <u>4015 BARRINGTON RD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>			<u>rev. yrs.</u>
Antecedent cause(s) (b) <u>Acute Myocardial Infarction</u>			<u>within 14</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/5</u> , 19 <u>55</u> , to <u>3/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>56</u> , and that death occurred at <u>7 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wm J. Kelly MD</u>		ADDRESS <u>5226 Balt. Nat. Pk</u>	DATE SIGNED <u>3/22/56</u>
23. BURIAL OR CREMATION (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3/23/56</u>	<u>BALTO HEBREW</u>	<u>BALTO BELAIR MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>3-22-56</u>	<u>Wm J. Kelly</u>	<u>David R. Martin 1902 Euteria Place</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0293793

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lisbon</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lisbon</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bryce Waters Gosnell</u>				4. DATE OF DEATH Month Day Year <u>March 9 1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 1899</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>S.R.C.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Amos L. Gosnell</u>				14. MOTHER'S MAIDEN NAME <u>Cordelia Franklin</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-03-0589</u>		17. INFORMANT Address <u>Mrs. Carrie Gosnell, Lisbon, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broken neck</u> DUE TO <u>812X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture rt elbow, compound</u> DUE TO <u>Fracture of left leg</u> (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by automobile while crossing Route 144</u> <u>in Lisbon</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7:30</u> a.m. <u>March 9 1956</u> p.m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 144</u>		20f. (City or town) (County) (State) <u>Lisbon Howard Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.									
ACTUAL SIGNATURE <u>B.D. Thomas</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B.D. Thomas</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>3-9-1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-13-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u>			22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.M. Waltz</u> <u>Winfield, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 12 March 1956</u>		24b. REGISTRAR'S SIGNATURE <u>E. Pearl Moring</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 14 1956

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2960

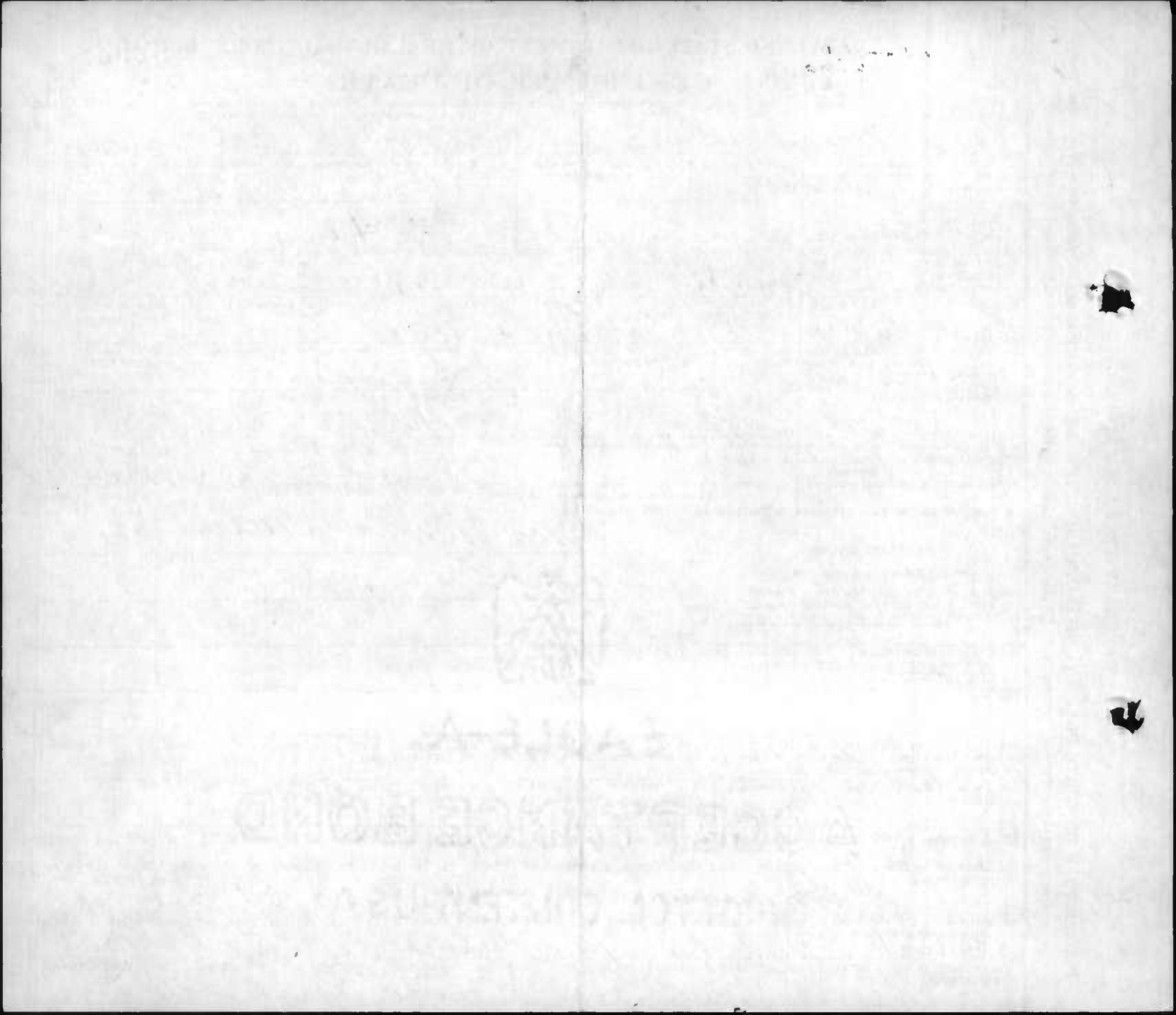
CERTIFICATE OF DEATH 2

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Haward</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Haward</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hanover</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hanover</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hanover Rd</i>		STREET ADDRESS (If rural give location) <i>Hanover Road</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Florence</i>	(Middle) <i>S.</i>	(Last) <i>Swynn</i>	(Month) <i>Mar.</i> (Day) <i>3</i> (Year) <i>1956</i>
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>Dec. 4, 1899</i>
9. AGE last birthday <i>56</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<i>Housewife</i>		<i>None</i>	
11. BIRTHPLACE (State or foreign country): <i>Hanover, Pa.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Joseph Dorsey</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Hill</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No. <i>mi</i>	
17. INFORMANT'S ADDRESS: <i>Florence S. Swynn, Hanover Road, Hanover, Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) <i>Cardio Valvular Disease</i>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Mar 2, 1956</i> , to <i>Mar 3, 1956</i> , that I last saw the deceased alive on <i>Mar 3, 1956</i> , and that death occurred at <i>4:15 PM</i> from the causes and on the date stated above.			
SIGNATURE <i>Thorpe Moultrie</i>		DATE SIGNED <i>3/4/56</i>	
M. D.		ADDRESS <i>Rt 4 Box 212 Elvinsville, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Buried</i>		<i>Mt. Auburn</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Mar 6, 1956</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. H. H.</i>	
		ADDRESS <i>231 S. Main St. Hill</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02939
Reg. Dist. No. 190

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1 Waterloo				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1000 feet north Waterloo Police Barracks				d. STREET ADDRESS 318 Main Street			
3. NAME OF DECEASED (Type or print) First Middle Last EDITH DOREEN JIANNINE				4. DATE OF DEATH Month Day Year March 2 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-24-1928	
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Lunch Room		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? Canada							
13. FATHER'S NAME Norman E. Donoghue				14. MOTHER'S MAIDEN NAME Mabel Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address N. E. Donoghue, Kingston, Ont. Canada			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Skull at base 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH Instant							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) North bound car struck utility pole east side of road					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12.15 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Waterloo Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE: <i>George E. Burgtorf</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) removed		22b. DATE THEREOF 3-4-56		22c. NAME OF CEMETERY OR CREMATORY Friendship		22d. LOCATION (City, town, or county) (State) Red Bank, N.J. Buena Vista, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE 3-6-56		24b. REGISTRAR'S SIGNATURE <i>Miss E. Paul Wilkes</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing in word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES J. HARRIS		Male		45		11-1-1908	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1001 East North		Police Detective		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
11-1-1956		Home		10:30 AM		Normal	
SIGNATURE OF EXAMINER		TITLE		SIGNATURE OF WITNESS		TITLE	
J. J. HARRIS		Police Detective		J. J. HARRIS		Police Detective	
DATE OF EXAMINATION		PLACE OF EXAMINATION		TIME OF EXAMINATION		TEMPERATURE	
11-1-1956		Home		10:30 AM		Normal	
SIGNATURE OF WITNESS		TITLE		SIGNATURE OF WITNESS		TITLE	
J. J. HARRIS		Police Detective		J. J. HARRIS		Police Detective	
DATE OF EXAMINATION		PLACE OF EXAMINATION		TIME OF EXAMINATION		TEMPERATURE	
11-1-1956		Home		10:30 AM		Normal	

BUREAU V. S.

MAR 7 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1 2952 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

02945

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup				c. LENGTH OF STAY IN 1b 50 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup				d. STREET ADDRESS Waterloo Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waterloo Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgianna Middle Litchfield Last Litchfield				4. DATE OF DEATH Month March Day 10 Year 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 5, 1860	
9. AGE (In years last birthday) 96 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Kanley				14. MOTHER'S MAIDEN NAME Mary Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Miss Marjorie Hampton			
17. INFORMANT 2123 Eye St. NW				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 491X DUE TO Common cold. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 wks. DUE TO (c) 2 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 25, 1956 to March 10, 1956 , that I last saw the deceased alive on Mar. 10, 1956 , and that death occurred at 7 P. M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Dorsey, Md. DATE SIGNED 3/12/56			
ACTUAL SIGNATURE Frank Shipley M.D.				PHYSICIAN'S NAME (Type) Dr. Frank Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF March 14, 1956			
22c. NAME OF CEMETERY OR CREMATORY Zion Cemetery				22d. LOCATION (City, town, or county) (State) Dorsey, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Howard Law ADDRESS Walter Howard Law				24a. REC'D BY REGISTRAR Dr. Frank Shipley DATE 4 1956			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES HENRY		MALE		35		JANUARY 1, 1910		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
RACE		COLOR		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
WHITE		WHITE		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL		HOME	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF DEATH		TIME OF DEATH	
JANUARY 15, 1955		10:00 AM		NEW YORK		NEW YORK		NEW YORK		NEW YORK		JANUARY 15, 1955		10:00 AM	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF DEPUTY REGISTRAR		SIGNATURE OF DEPUTY REGISTRAR		SIGNATURE OF DEPUTY REGISTRAR	

BUREAU V. S.

MAR 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1802941
2963 CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ellicott City Rural</u>	LENGTH OF STAY (in this place) <u>12 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City Rural</u>	
HOSPITAL OR INSTITUTION DR STREET ADDRESS <u>Box 44 R.F.D. 1</u>		STREET ADDRESS (If rural give location) <u>Box 44 R.F.D. 1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Thomas Lewis</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 12 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Apr 17 - 1878</u>
9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Coal Miner</u>	
11. BIRTHPLACE (State or foreign country): <u>Carroll's md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Lewis</u>		14. MOTHER'S MAIDEN NAME: <u>Harriett Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO.: <u>214-24-3822</u>	
17. INFORMANT & ADDRESS: <u>R.F.D. Box 44 Ellicott City, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocarditis</u>			<u>4 mo</u>
ANTECEDENT CAUSE (S) <u>Saccular Bronchitis</u>			<u>4 mo</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>General Arteriosclerosis</u>			<u>1 1/2 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 15, 1955</u> , to <u>March 12, 1956</u> that I last saw the deceased alive on <u>March 12, 1956</u> and that death occurred at <u>8 15</u> M., from the causes and on the date stated above.			
SIGNATURE <u>B. Brumbaugh</u>		ADDRESS <u>M.D. 3609 main st Ellicott City Md</u>	
DATE SIGNED <u>3/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/15/56</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. STEPHENS</u>		LOCATION (City, town, or county) (State) <u>ELLCOTT CITY MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 15, 1956 (mcc)</u>		REGISTRAR'S SIGNATURE <u>E. B. Williams</u>	
24. FUNERAL DIRECTOR <u>F. HIGGINS BORTHOM</u>		ADDRESS <u>ELLICOTT CITY MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 16 1956

BUREAU V. 8

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02942

2964

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Howard		MARYLAND		STATE Maryland		COUNTY Howard	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN Ellicott City				TOWN Ellicott City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Johns Lane				STREET ADDRESS (If rural give location) St. Johns Lane			
3. NAME OF DECEASED (First) (Middle) (Last) FANNIE LIVELY				4. DATE OF DEATH (Month) (Day) (Year) March 7 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 28 1876		9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Owen Leatherwood				14. MOTHER'S MAIDEN NAME Sarah Nye			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT & ADDRESS Mrs. Orville Mellor, Ellicott City, Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) MYOCARDIAL FAILURE						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
ANTECEDENT CAUSE(S) DUE TO (B) CORONARY ATHEROSCLEROSIS						YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) VASCULAR SENILITY						YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. OBESITY							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 19 55, to MARCH 19 56, that I last saw the deceased alive on MARCH 6, 19 56, and that death occurred at 3:05 P.M. from the causes and on the date stated above.							
SIGNATURE Donald E. Fisher				ADDRESS (Street, city, town, state) Ellicott City, Md		DATE SIGNED 3-7-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-10-56		NAME OF CEMETERY OR CREMATORY Mt. Pleasant		LOCATION (City, town, or county) (State) Gamber, Md.	
24. REC'D BY REGISTRAR DATE March 8, 1956		REGISTRAR'S SIGNATURE John B. Loughman Jr.		25. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham		ADDRESS Ellicott City, Md	

B. E. L.



BUREAU V. S.

MAR 12 1956

RECEIVED

U.S. Department of the Interior, Bureau of Land Management

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02943

2965

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY Howard

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

TOWN Ellicott City

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Highland Manor Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore

STREET ADDRESS (If rural, give location)

2512 Guilford Avenue

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

5. SEX:

female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Jan. 9, 1880

4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 12, 19 56

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

76 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

housewife

10b. KIND OF BUSINESS OR INDUSTRY:

at home

11. BIRTHPLACE (State or foreign country):

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Martin Anderson

14. MOTHER'S MAIDEN NAME:

Phebe Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Madeline Roberts, 147 Oaklee Village

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0

Immediate cause

(a).....

Arteriosclerosis Heart Disease

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

Arteriosclerosis Heart Disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

many yrs.

many yrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Bronchopneumonia

3 days

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1955, to Jan., 1956, that I last saw the deceased alive on Mar. 7, 1956, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

Wm. J. Kelly MD

5226 Bold Nat Pl

DATE SIGNED 3/13/56

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-13-56

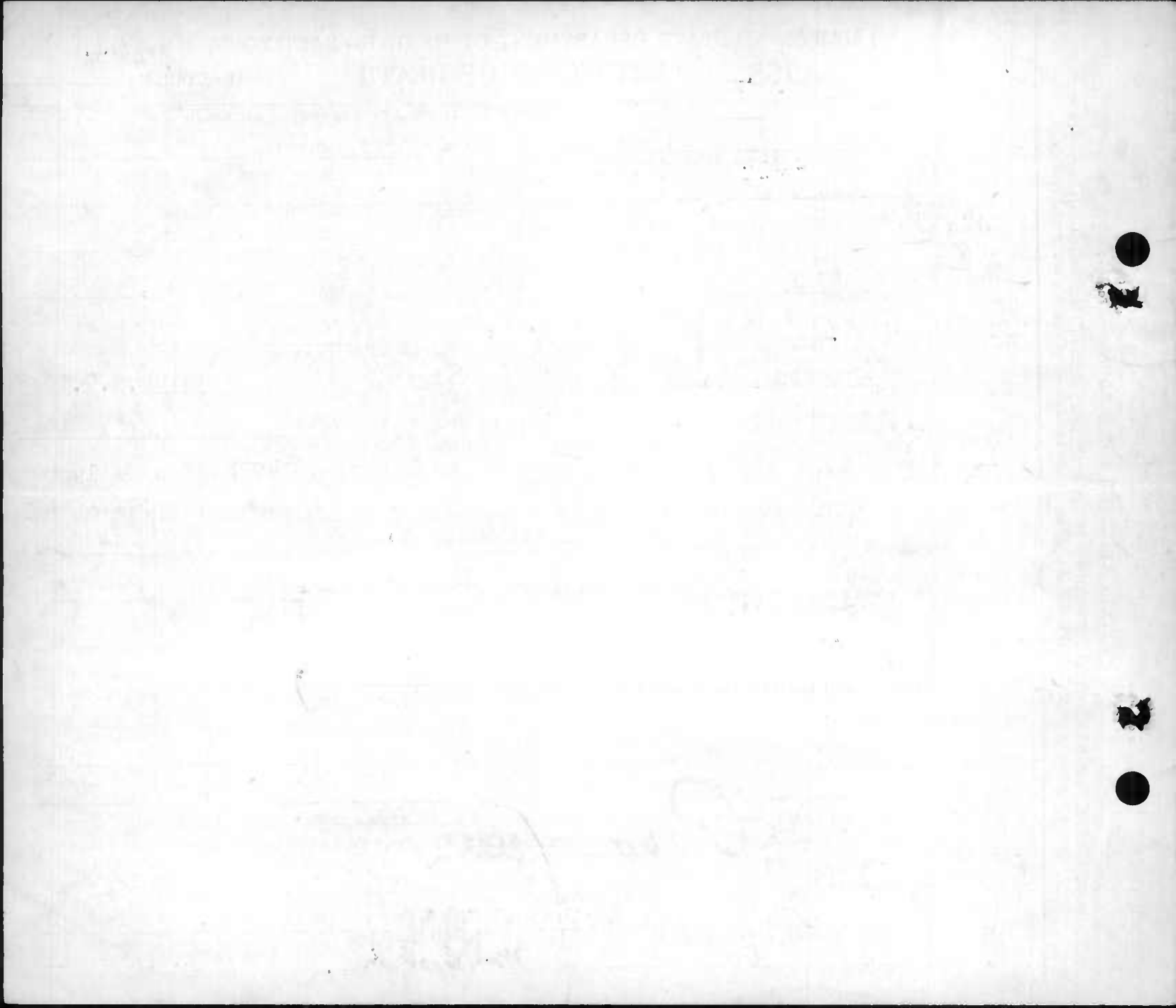
Wm. Cook Inc.

1217 St. Paul Street

1217 St. Paul Street

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

195

2956

1. PLACE OF DEATH a. COUNTY <i>Howard Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <i>md.</i> c. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Junction</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Junction</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Mary E.</i> Middle <i>Saumenis</i> Last <i></i>				4. DATE OF DEATH Month <i>3</i> Day <i>30</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1874</i>	9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Same</i>		11. BIRTHPLACE (State or foreign country) <i>Lewisville, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lewis Harden</i>				14. MOTHER'S MAIDEN NAME <i>Mary Roberts</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Mrs. Mildred Linder, Annapolis Junction, Md.</i>		Address <i>Annapolis Junction, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> (c) <i>Senile Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 wk - 15 yrs - 15 yrs -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senile Dementia</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1/23</i> , 1956, to <i>3/30</i> , 1956, that I last saw the deceased alive on <i>2/3</i> , 1956, and that death occurred at <i>12:45</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. M. Warren</i> M.D.				ADDRESS (Street, city or town, state) <i>Lewisville, Md.</i> DATE SIGNED <i>3/30/56</i>			
PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/2/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harold Davidson</i> ADDRESS <i>Howard, Md.</i>				24a. REC'D BY REGISTRAR <i></i> DATE <i>4/2/56</i>		24b. REGISTRAR'S SIGNATURE <i>Frank Shipley</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. This certificate has been signed by the attending physician and completed. It should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02944

2967 CERTIFICATE OF DEATH

Reg. Dist. No. 170

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Howard</u>		STATE <u>Maryland</u> COUNTY <u>Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>	
TOWN <u>Hanover</u>		LENGTH OF STAY (in this place) <u>18 yrs.</u>		TOWN <u>Hanover</u>		TOWN <u>Hanover</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 129, Hanover Road</u>				STREET ADDRESS (If rural give location) <u>Box 129, Hanover Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARGARET MARIE SCHMIDT</u>				<u>March 28, 1956.</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>January 7, 1906.</u>	
9. AGE last birthday <u>50</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Prat.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Milton Pickett</u>				14. MOTHER'S MAIDEN NAME <u>Hester Lowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-03-3377</u>		17. INFORMANT & ADDRESS <u>Box 129 Hanover Road Oscar Schmidt, Hanover, Maryland.</u>	
18. MEDICAL CERTIFICATION				19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Esophagus 6 mo</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>General Carcinomatosis 3 mo</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Dec 15, 1955</u> , to <u>Mar 28, 1956</u> , that I last saw the deceased alive on <u>Mar 28, 1956</u> , and that death occurred at <u>11:38</u> M., from the causes and on the date stated above. <u>3/29/56</u>							
SIGNATURE <u>B. B. Brumbaugh</u> M.D. <u>5609 main st Edmdrds</u>				DATE SIGNED <u>3/29/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 31, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodbine, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>(min) L. Bidwill</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		ADDRESS <u>Catonsville 28, Md.</u>	
DATE <u>March 31, 1956</u>							

2007 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGY

18. SIGNATURE OF BURIAL

19. SIGNATURE OF CREMATION

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

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100. SIGNATURE OF OTHER

101. SIGNATURE OF OTHER

BUREAU V. S.

APR 3 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02945

2968 CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Howard County</u>		STATE <u>MARYLAND</u>		STATE <u>Pennsylvania</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ellicott City</u>		LENGTH OF STAY (In this place) <u>19 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Coverdale</u>		<u>75 X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Taylor Manor Hospital</u>				STREET ADDRESS (If rural give location) <u>540 S. Hickory Street</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>SIROCHMAN</u> (Last)				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES KRATT</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records Ellicott City</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Myocardial) and <u>Cardiac/decompensation/failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
443X IMMEDIATE CAUSE (A)				Antecedent Cause(S) DUE TO		(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO		(C)	
				<u>Hypertensive cardio vascular disease</u>		<u>10 years</u>	
				<u>Arteriosclerosis - generalized</u>		<u>10-15 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Rheumatoid arthritis</u>		<u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 Feb 56</u>, to <u>3 Mar</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>2 Mar</u>, 19 <u>56</u>, and that death occurred at <u>7:50AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur J. McCallan M.D.</u>		ADDRESS (Street, city, town, state) <u>Taylor Manor Hospital Ellicott City Maryland</u>		DATE SIGNED <u>3 MAR 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>JEFFERSON MEM. CEM. PITTSBURGH, PA.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <u>MAR 5 1956</u>		REGISTRAR'S SIGNATURE <u>John T. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. ...</u> ADDRESS <u>901 S. CONKLINGS BALTO., 24, MD.</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text, possibly "John Doe"]		2. PLACE OF DEATH [Faint text, possibly "City of Baltimore"]	
3. SEX [Faint text, possibly "Male"]		4. AGE [Faint text, possibly "35 years"]	
5. DATE OF DEATH [Faint text, possibly "April 15, 1936"]		6. TIME OF DEATH [Faint text, possibly "10:30 AM"]	
7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		8. MANNER OF DEATH [Faint text, possibly "Natural"]	
9. SIGNATURE OF PHYSICIAN [Faint signature]		10. SIGNATURE OF REGISTRAR [Faint signature]	

RECEIVED
 MAR 6 1936
 BUREAU V. 5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 191									
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rogers Ave.</u>					d. STREET ADDRESS <u>Rogers Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JAMES SHELBY STREAKER</u>			First Middle Last		4. DATE OF DEATH <u>March 24 19 56</u>		Month Day Year		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1943</u>			9. AGE (In years last birthday) <u>12</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Aquilla Streaker</u>					14. MOTHER'S MAIDEN NAME <u>Helen K. Blankenship</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Aquilla Streaker, Ellicott City, Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia - hanging</u> 936.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found hanging by rope with gag in mouth in barn</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>3:16</u> p. m. <u>3/24/56</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>barn at home</u>		20f. (City or town) (County) (State) <u>Rural Howard Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE <u>Russell S Fisher</u>			M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>3/25/56</u>			
EXAMINER'S NAME (Type) <u>Russell S Fisher</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>3-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GOOD SHEPHERD</u>		22d. LOCATION (City, town, or county) (State) <u>ELLICOTT CITY Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. G. HIGGINBOTHAM</u>					ADDRESS <u>1301 THOMAS, ELICOTT CITY MD</u>		24a. REC'D BY REGISTRAR <u>March 27, 56</u>		24b. REGISTRAR'S SIGNATURE <u>John B. Loughran, Per</u> B. E. L.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	

MARYLAND STATE DEPARTMENT OF HEALTH

02947

2970

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Howard Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodstock, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodstock, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Florence H. A. Willett</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3/13/56</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 19, '99</u>
9. AGE last birthday <u>57</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles E. Willett</u>		14. MOTHER'S MAIDEN NAME <u>Florence -----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Marie E. Long Woodstock, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Edema

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Left Heart Failure6 mos.

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/5, 1956, to 3/13, 1956, that I last saw the deceasedalive on 3/13, 1956, and that death occurred at 9:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/17/56</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 17 - 1956</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>	ADDRESS <u>715 Light St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

